STATE
OF
ALABAMA

DEPARTMENT OF INDUSTRIAL
RELATIONS

WORKERS' COMPENSATION DIVISION

INDUSTRIAL RELATIONS BUILDING
MONTGOMERY, ALABAMA 36131
(334) 242-2868
TDD MESSAGE: 1-800-548-2546

WC Form 18
Revised 1-93

EMPLOYER'S APPLICATION FOR SELF INSURANCE
(Submit one completed copy)

CONFIDENTIAL

To the DEPARTMENT OF INDUSTRIAL RELATIONS:

The undersigned, an employer subject to the provisions of the Alabama Workers' Compensation law, as last amended, hereby applies for the privilege of self-insuring the payment of compensation provided in that law, and submits the following facts under oath to the Department of Industrial Relations to enable it to determine if sufficient financial ability exists to render certain the payment of such compensation:

1. Name of Applicant _____

2. Address _____
(Number) (Street) (City or Town) (County) (State) (Zip)

P. O. Box _____
(Number) (City or Town) State (Zip)

Telephone ( ) _____ ALA U. C. Number _____

EMPLOYER IDENTIFICATION NUMBER _____

3. The applicant is _____
(State whether individual, co-partnership, limited partnership, corporation, receiver or trustee)

4. **Describe briefly the general character of the operations performed and the articles manufactured or compounded at or away from the plant or premises of the applicant.**

_____

_____

_____

_____

5. **Description of employment:**

Location of Plant or Plants	Kind of Employment	Estimated average number of employees at all points	Estimated average number of employees in Alabama	Estimated pay roll of all Alabama employees for ensuing year

6. If a Corporation or Limited Partnership list below names of officers, directors, and residence of each:

NAME	OFFICIAL TITLE	ADDRESS

7. If a Limited Partnership, give date of formation and duration _____

_____

8. If a Partnership, list below names of members and residence of each _____

_____

_____

_____

9. If Individual, give name and residence _____

_____

_____

_____

_____

10. If a Corporation, answer the following: Chartered under the laws of the State of _____

Date of incorporation _____ Authorized Capital Stock: (Common) $ _____

(Preferred) $ _____

11. Is applicant a subsidiary? _____. Give name and address of parent company _____

_____

_____

_____

(Subsidiaries must have separate applications and indemnity agreements)

12. If foreign corporation, give address of Home Office _____

_____

_____

_____

13. Date when self-insurance is desired _____ 19____ 12:01 a.m.

14. Are you now complying with Section 25-5-8 of the Law, by carrying workers' compensation insurance on your employees? If so, indicate the name of the insurance company (not local agent) with whom you are insured.

_____

_____

_____

15. **What is the expiration date of your present policy?** _____

16. Are you now, or have you been within the past three years, an assigned risk for workers' compensation insurance? (Give dates and details on separate page, if necessary)

_____

_____

17. As a self-insurer, will you deal directly with your employees in workers' compensation matters, or through an approved service organization? If the latter method is to be used, give name and address of the organization.

_____

_____

_____

18. **Past three-year Accident Experience:** **19____** **19____** **19____**

Number of deaths _____ _____ _____ _____

Alabama Workers' Comp Premiums $ _____ $ _____ $ _____

Alabama Workers' Comp Incurred Losses $ _____ $ _____ $ _____

19. Are there any outstanding unpaid judgments subject to execution rendered against the applicant under the provisions of the Workers' Compensation Law, as last amended? (Give amounts and details on separate page, if necessary)

_____

_____

20. Applicant must attach audited or certified financial reports for the prior three years of operation.

21. Applicant must submit a $250.00 application fee with each application submitted. Make payable to: Department of Industrial Relations Workers' Compensation Administrative Trust Fund.

22. Name of excess insurance carrier (if any) _____

Amount of Retention $ _____ Specific, Aggregate, or both? _____

23. Relate facts, covering past three years:

Year Ending	Sales (Omit cents)	Expenses (including payroll)	Payroll	Profit or Loss (Specify)
19				
19				
19				

24. Has the applicant, or its parent corporation, ever filed for bankruptcy? _____ If yes, give details on separate sheet.

AGREEMENT CONDITIONS

25. In consideration of the approval of this application, the applicant expressly agrees:

(a) That this privilege may be revoked at any time in the discretion of the Director of Industrial Relations as provided in Section 25-5-8(d1) of said Law, as amended.

(b) That the applicant will promptly furnish adequate hospital, medical, surgical, and burial benefits within the limits of the Law.

(c) That the applicant will discharge liability for compensation to injured employees or their dependents in accordance with said Law's requirements.

(d) That reports will be promptly furnished the Department in strict accordance with Sections 25-5-4, 25-5-5 and 25-5-7 of said Law.

(e) That the applicant will not solicit, receive or collect from his employees, any part of the cost to him of operating under this Law.

That the applicant will promptly notify the Department upon insuring his workers' compensation liability with a private casualty insurance company, thereby cancelling his self-insurance privileges.

(g) That a copy of the company's annual report, or statement of assets and liabilities, will be mailed to the Department at the close of each fiscal year, as evidence of continued financial ability to self-insure its liability under said Law.

(Signed) .....

(Title) .....

STATE OF .....

COUNTY OF .....

....., being first duly sworn, appeared personally and declared that the facts set forth in the foregoing application are true to the best of his knowledge, information and belief.

Subscribed and sworn to before me, this .....day of....., 19.....

.....

(Notary Public)

(SEAL)

My commission expires on the.....day of....., 19.....